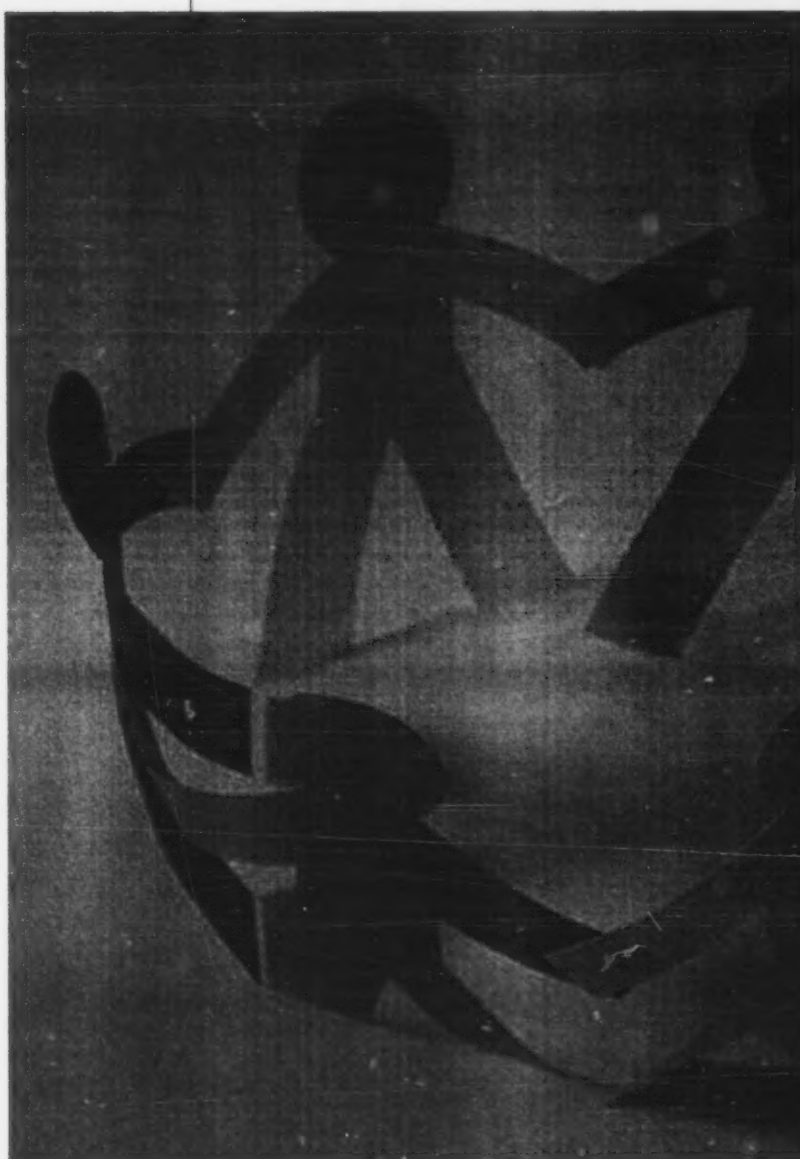


COLLECTIVE WILL



"Through the Quality as a Business Strategy initiative, a collective will is growing in Saskatchewan to become an intentionally designed health care system that thinks and works as one system, driven by the needs of patients, and built upon an effective, coordinating, integrating foundation."

Dr. Doug Eby, Vice-President of Medical Services,
Southcentral Foundation (Alaska)

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THE HEALTH QUALITY COUNCIL (HQC) IS AN INDEPENDENT AGENCY THAT MEASURES AND REPORTS ON QUALITY OF CARE IN SASKATCHEWAN, PROMOTES IMPROVEMENT, AND ENGAGES ITS PARTNERS IN BUILDING A BETTER HEALTH SYSTEM.

OUR VISION:

Saskatchewan residents have the highest quality of health care.

OUR MISSION:

To improve the quality of care and the caring experience in Saskatchewan.

OUR DEFINITION OF QUALITY:

Quality health care is care that is accessible, safe, effective, patient-centred, timely, efficient, and equitable.

OUR WORK IS GUIDED BY FOUR PRINCIPLES:

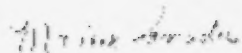
- Partnerships with stakeholders are essential. We cooperate with health system stakeholders at all stages of improvement initiatives. Moreover, users of the health system are integrally involved and their input sought in all of our improvement activities.
- The pursuit of excellence must be relentless. We strive to match or exceed leading practices from around the world.
- Evidence should inform and measurement drive all activities. We ensure accurate measurement and reporting throughout the system, and recommend improvements to health care that are grounded in the best available evidence, and
- Systems thinking is fundamental. Health care is delivered by a complex system. Our experience and growing knowledge tell us that lasting gains in quality are more achievable when our collective focus is on systems rather than individual components or individual care providers. As such, interprofessional collaboration is critical to achieving optimal quality in the health system.

LETTER OF TRANSMITTAL

The Honourable Don McMorris
Minister of Health
Room 302, Legislative Building
Regina, Saskatchewan
S4S 0B3

Dear Mr. McMorris:

I am pleased to submit the annual report for the Health Quality Council. This report for 2008 – 2009 fiscal year is submitted in accordance with the requirements of *The Health Quality Council Act* and *The Tabling of Documents Act*.



Marlene Smadu
Board Chair
Health Quality Council

MESSAGE FROM THE BOARD CHAIR



Catalyst, connector, constructive agitator. Many different terms can be used to describe the role of the Health Quality Council (HQC). We try to spark the system to transform itself in the name of delivering better health care to Saskatchewan residents. We work to bring people together to begin thinking, acting, and making decisions as one system. And we are constantly challenging our partners and ourselves to question the way we've always done things in health care.

Last spring, we worked with the provincial Ministry of Health to bring Helen Bevan to Saskatchewan. This vibrant leader from the National Health Service's Institute for Innovation and Improvement shared with us important lessons about what it takes to transform an entire health care system. Through our June 2008 conference on transparency in health care, we invited leaders from across our provincial health care system, and across the country, to learn how systems elsewhere in North America are using measuring and reporting on quality to learn and improve.

As part of the Quality as a Business Strategy (QBS) learning collaborative, we brought together leadership teams from our health care system to hear from their counterparts at Sweden's Jönköping County Council and Alaska's Southcentral Foundation about their journeys to become top-calibre health care systems. Our guests are very busy people in high demand around the world; they came to Saskatchewan because they can sense the strong will and ambition there is for transformation in this province.

Through QBS, HQC is providing the forum and environment for what have been unprecedented discussions about what changes we need to truly organize and deliver health care as a "system." The workshops have, at times, led to some difficult and challenging conversations, but this dialogue has been important and highly productive.

In September, I had the privilege of being part of a team that travelled to England to study the Releasing Time to Care[®] initiative in the National Health Service. The group included the Minister of Health, Deputy Minister of Health, key nursing leaders, and health region representatives in the Saskatchewan health system. The support and collaboration of all of those organizations has made the launch of Releasing Time to Care[®] in Saskatchewan possible and effective, and we are looking forward to the same successes experienced in England.

In October we introduced the new Quality Insight reporting program, which will serve as the foundation for measuring quality in Saskatchewan's health care system. As is the case with all we do, we are engaging with our audiences to ensure that the program and its quality reports are relevant and useful to regions and government.

The past year also saw considerable collaboration to more fully engage physicians in quality improvement and system change. It was exciting to work alongside the Saskatchewan Medical Association, College of Physicians and Surgeons, and Ministry of Health to support a large delegation of Saskatchewan doctors to attend the Institute for Healthcare Improvement's National Forum in Nashville.

Our board recognizes that health system transformation does not happen overnight. It is a long journey we have started. We are committed though, to working with our colleagues to bring to this province the key elements required for system-wide transformation, including leadership and capability for improvement, the spread of best practices, measurement infrastructure, engaged providers, and policy that supports continuous quality improvement.

It was with mixed feelings that we bid farewell to our Board Chair, Dan Florizone, who was appointed Deputy Minister of Health. We miss his presence at our table, but take solace in having a colleague in this important post. We also said goodbye to John Conway, who moved to Ontario; his contributions to HQC's work too were greatly appreciated. We welcomed two new board members, Maura Davies, CEO of Saskatoon Health Region, and Don Hoirom, Director of Education for the Regina Public School Division. Our work is sure to benefit from their fresh insights and experience. We have a committed, engaged, and visionary board, with whom I am proud to work.

Sincerely,

A handwritten signature in dark ink, appearing to read "Marlene Smadu".

Marlene Smadu
Board Chair

MESSAGE FROM CEO



The past year has, for me, been one of humility and of ensuring that our organization is living the same principles and values we are promoting in Saskatchewan's health care system.

Through the Quality as a Business Strategy learning collaborative, our organization – along with our health system colleagues – has had the privilege of rubbing shoulders with some of the top health care systems from around the world. While we learned a lot, we still have a long way to go in applying the principles that make Sweden's Jönköping County Council and Alaska's Southcentral Foundation high-performing systems. It is humbling too to be working through our own leadership learning journey alongside our Saskatchewan health care colleagues. We have much to learn about hearing the voice of our customer, and measuring how effectively we are listening and responding to that voice.

The Health Quality Council has always advocated using evidence to inform and measurement to drive all activities in health care. To ensure we are deploying our resources in the best possible manner to support our colleagues, we have implemented a new project management system within our organization. This new tool is providing us with the information we need to improve project planning.

In the same way that we are working to build capability in the Saskatchewan health care system, we are similarly committed to developing in our staff the knowledge and skills they need to support managers and

providers outside our organization. During the past year, we completed the successful first waves of Quality Improvement Consultant school and Clinical Practice Redesign school. While many things about these new learning programs went well, we recognize that there is always room for improvement. We are attentive to the voice of our customers, and have built this feedback into redesign for subsequent waves of these capability building programs.

Planning for the second Chronic Disease Management Collaborative is well underway. We are excited to be building upon the lessons we learned in the first Collaborative, as we work with practices to improve care for Saskatchewan people living with depression and chronic obstructive pulmonary disease (COPD).

It has been my privilege to sit on the steering committee for the Patient First Review. I firmly believe this initiative is helping to lay the foundation for transforming our health care system in this province. But this cannot be a one-time exercise. That is why it is so encouraging that our former Board Chair, now the Deputy Minister of Health, Dan Florizone, has committed to hearing the voice of our ultimate customer, Saskatchewan residents, on an ongoing basis.

Of course, none of the work of the Health Quality Council would be possible without the dedication and energy of our staff. Ours is a curious, passionate, and committed team. We could not have come as far as we have in six years if it were not for

their collective, collaborative efforts in pursuit of our mission. In the past year, we have begun having important conversations about who we are as an organization, and how we work together. I am indebted to my colleagues and committed to nurturing an environment where these talented individuals can thrive and grow as professionals and as people.

A stylized, handwritten signature of Bonnie Brossart in dark ink.

Bonnie Brossart
Chief Executive Officer



**BUILDING CAPABILITY AND LEADERSHIP
TO IMPROVE AND SUSTAIN QUALITY**

Through the new Accelerating Excellence initiative, we are working with our colleagues to nurture in this province the attributes common to high-performing systems elsewhere in the world.

ACCELERATING EXCELLENCE (AE)

Although Saskatchewan – like most other provinces – continues to spend an increasing proportion of its resources on health care, gaps continue to persist between optimal and actual care. We received an additional \$5 million in funding at the end of the last fiscal year to move from incremental, piecemeal improvements in quality and performance toward true system-wide transformation. Through the new Accelerating Excellence initiative, we are working with our colleagues to nurture in this province the attributes common to high-performing systems elsewhere in the world: leadership focused on quality; capability throughout the system for improvement; an engaged health care workforce; measurement infrastructure to learn and improve; and, health policy that supports improvement.

QUALITY AS A BUSINESS STRATEGY (QBS)

Research on high-quality health care systems shows that having leadership focused on quality is key to achieving patient-centred transformation. Governors and senior managers play an instrumental role in building within their organizations a culture of quality and continuous improvement. Through the Quality as a Business Strategy leadership learning collaborative, we are helping organizations incorporate a quality focus into their strategic planning and operations, and to sustain

improvements. QBS is exposing Saskatchewan leaders to counterparts from health care systems that have transformed themselves. It is providing a forum for important conversations. And it is providing leaders time to step back from their day-to-day busyness to focus on this all-important work.

QBS is based on a framework developed by Associates in Process Improvements, who created their model using the concepts of the grandfather of systems thinking and quality, W. Edwards Deming. The key elements of the QBS program are defining the purpose of an organization, understanding the organization as a system, using information to improve, planning improvement, and managing improvement. The mainstay of the QBS program is a series of workshops, the first of which took place in Saskatoon in October 2008. Twenty-two health care organizations assembled their own teams to participate in the program; they were encouraged to include senior managers and board members.

To date, QBS is the largest element within the Accelerating Excellence portfolio. It is bringing together more than 200 leaders from across the province's health care system, including all health regions, the Saskatchewan Cancer Agency, First Nations, the Ministry of Health, regulatory bodies for doctors, nurses, and pharmacists, the Health Quality Council, and other organizations.

The orientation workshop in October 2008 featured representatives of the renowned Jönköping County Council in Sweden, which used QBS as the framework for its decade-long transformation journey. Göran Henriks and Mats Bojestig reminded Saskatchewan health care leaders that change truly starts with them, that the hardest part of system transformation is taking the first step, that care must be organized and delivered according to what's best for the patient, and that real change can happen only after we have honestly examined how we currently do things.

In January 2009 QBS participants had the opportunity to engage with leaders from Alaska's inspiring Southcentral Foundation, a health care system that reinvented itself to better meet the needs of the local Native population. Southcentral's CEO Katherine Gottlieb and her team talked about the importance of leaders empowering their organizations to change and improve, seeing the people we serve as "customer-owners" rather than passive recipients of care, and capturing the "voice of the customer" through many different channels.

The QBS learning workshops have created a forum for unprecedented and – at times, difficult – conversations about the need to work together as a system rather than a collection of disparate parts. These discussions in fact led us to rethink our

When Julie Johnson enrolled in the HQC's Quality Improvement Consultant (QIC) Program, she had already been working with a small team on a medication reconciliation pilot project for five months. For her QIC Program project, Johnson chose to work on spreading the patient safety initiative within the Regina Qu'Appelle Health Region (RQHR). Even she couldn't have imagined that, within a year, it would be adopted in 25 additional units, seven rural acute care

original plan to allocate a portion of AE resources through a competitive process, to support a handful of health regions transform one of their care streams. We initially felt that spreading financial resources across all regions would dilute any potential impact. However, we are now working with regions, government, and other system colleagues to determine the best strategy for sharing these resources to help all participating organizations improve care for the patients we serve.

CLINICAL PRACTICE REDESIGN (CPR) SCHOOL

Through a new program called Clinical Practice Redesign (CPR) school, we worked to build capability within family physician and specialist practices, and regionally delivered programs, to improve the way they manage medical appointments. CPR school borrows from proven process improvement methods, including an approach called Advanced Access, which requires developing a deeper understanding of your supply of, and demand for, appointments. The model has proven very successful across many care settings in shortening wait times for patients, reducing "red snows," and increasing the satisfaction of patients and office staff. The main objectives of CPR school were to improve patient access in participating sites, and to build capacity among participants to apply their learning to other access challenges.

Evidence shows that access to medical appointments is a key element in improving care for patients with chronic conditions such as diabetes or coronary artery disease. Because clinical content for our first Chronic Management Disease Collaborative required such a sizeable portion of the agenda, however, there was not sufficient time to teach participants how to reorganize appointment processes.

Expert advisor to our program was Catherine Tantau, an access guru who was instrumental in the development of the model taught in our CPR program, and has worked with hundreds of organizations in U.S. and Europe, including the UK's National Health Service and Kaiser Permanente in California.

Wave 1 of CPR school, which ran from April through November 2008, involved an eclectic group from across the province that included improvement advisors from the first Chronic Disease Management Collaborative, family doctors and specialists, and staff from regional programs (including physical therapy, mental health, public health, and podiatry). The Saskatchewan Medical Association and Ministry of Health sponsored seven practices to participate. The experiences of the 29 participants in putting CPR principles into practice confirmed that the program's content and concepts are applicable across a wide variety of practice settings.

The program offered a rich forum for discussion and sharing of

ideas across practices and sites. CPR school also fostered conversations and increased understanding between family practices and specialist practices about the impact that processes in their respective offices have on other areas along the care path.

HQC intends to offer another wave of the program, this second one perhaps focused on a specific type of practice. As well, we will help participants in the second Chronic Disease Management Collaborative apply CPR principles in their practices to free up more time for, and improve patients access to, appointments. Optimal care for COPD and depression involves calling patients back for regular assessment.

Through our evaluation, we are determining the extent to which access has improved in those practices that had participants in the course. While we have heard reports of success in some practices and positive response to the new processes, these changes have not yet translated into shorter wait times or measurable improvements on other metrics.

QUALITY IMPROVEMENT CONSULTANT (QIC) SCHOOL

Twelve "students" took part in the first wave of another new capability building program—HQC launched last year. Between November 07 and November 08, a class of health care managers and providers came together for the inaugural Quality Improvement Consultant (QIC) school, to learn about the science

sites, and several ambulatory care services. "Just do it! Set aside weekly protected time to be fully engaged in all that the school has to offer," says Johnson. "Take advantage of the eagerness of the faculty to support you, and apply what you are learning as you go. Think of it as learning a whole new way of working, and plan to share this understanding and your new knowledge with your project team."

of quality improvement, and develop confidence and skills to lead and facilitate improvement work in their home organizations.

The program is modeled after the Institute for Healthcare Improvement's (IHI) Improvement Advisor course, of which several senior HQC staff are graduates. We created QIC school to provide Saskatchewan health care organizations with a similarly structured but more accessible, homegrown alternative.

Participants, who needed their own real world improvement project as a requirement for enrollment, came together for four workshops, then stayed connected during action periods through webinars and an online learning environment.

QIC curriculum is based on the most current literature on measurement and quality models (including Lean, Six Sigma, Reliability Science, and Clinical Practice Redesign) and includes regular and timely feedback on improvement project progress. The QIC school uses a tiered delivery approach, with content delivered through a mix of face-to-face workshops, webinars, online modules, and an online community. QIC school includes presentations by expert faculty and by the participants themselves, as well as small group assignments.

In addition to making significant progress toward achieving goals they'd set for their improvement projects, participants reported a deepened understanding of

increased confidence applying, and greater capacity for sharing their new knowledge about quality improvement, measurement, systems, and process improvement. Collectively, participants estimated they would – through teaching, consulting with, or mentoring – spread their learnings to hundreds of others in their home organizations over the next 12 months. Students in Wave 1 particularly appreciated the many opportunities they had to interact with their fellow participants and to apply skills they were learning. Wave 2 of the QIC Program, as it is now called, is scheduled to start in fall 09; in response to feedback from Wave 1 students, the next session will include more emphasis early on about how to identify and better understand system problems in need of quality improvement solutions.

ACADEMIC INITIATIVES PROGRAM

We continue to work with the University of Saskatchewan, University of Regina, and the Saskatchewan Institute of Applied Science and Technology to ensure that the health care workforce of the future has the tools and methods to make quality improvement an integral part of practice and service delivery.

With our partners, we have developed and delivered curriculum for a number of undergraduate programs, including Health Studies, Medicine, Nutrition, Pharmacy, and Physical Therapy. HQC has also worked with post-graduate

students from the Masters of Public Health and Family Medicine Residency programs.

Faculty development is key to this initiative. We are seeing growing interest among faculty in doing quality improvement research, which should in turn increase their capacity to teach QI to health sciences students and conduct further research in the area.



ENGAGING WITH PROVIDERS, PATIENTS,
AND THE PUBLIC TO IMPROVE QUALITY

Health systems that have transformed themselves to deliver high-quality, patient-centred care have actively engaged providers in change.

9

On Releasing Time to Care:

"It is an exciting opportunity to focus together on nursing strategies that improve patient outcomes and nursing leadership at the local level."

Donna Brunskill, executive director, Saskatchewan Registered Nurses Association.

"We are happy to commit resources to this process. We see great potential for positive outcomes for the people of Saskatchewan."

Cynthia Gutek, president, Saskatchewan Association of Licensed Practical Nurses.

"If our colleagues in the UK have figured out how to increase the hours of direct care per patient, and improve patient outcomes, we can do that here in Saskatchewan."

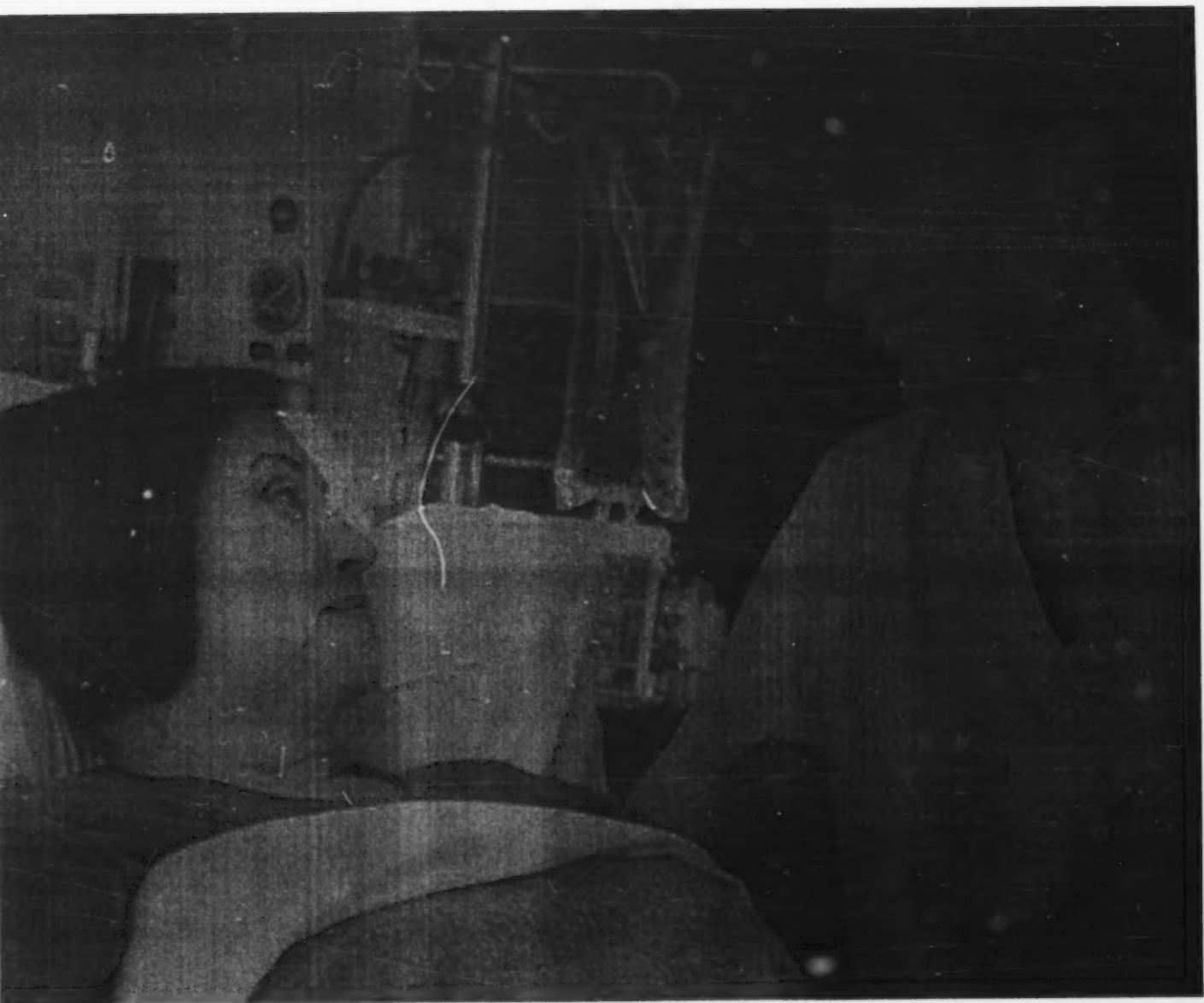
Rosalee Longmoore, president, Saskatchewan Union of Nurses.

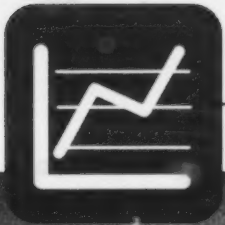
ENGAGING SASKATCHEWAN CITIZENS

While we did not hold an event specifically targeted at Saskatchewan citizens this year, we hosted a number of events through which we connected with representatives of the public. Our conference on transparency in health care in June stimulated discussion about making available publicly information on system performance and quality; the Quality as a Business Strategy learning workshops involved leaders who are working to improve organization and delivery of care for citizens they serve; and, the first edition of Quality Insight was publicly released through Saskatchewan newspapers and electronic media.

SHARED DECISION-MAKING

We have begun exploring how health care delivery organizations in Saskatchewan and abroad are involving patients more closely in decisions about their care. We want to identify best practices in this area, and determine what role HQC might play in supporting Saskatchewan health regions to apply shared decision-making with patients.





MEASURING AND REPORTING FOR LEARNING AND IMPROVEMENT

Our aim is for Quality Insight to become a valued resource for health care leaders and decision-makers in their quest for continuous improvement.



QUALITY INSIGHT

One of HQC's fundamental mandates is to measure and monitor the quality of health care in Saskatchewan. Health systems around the world that are leaders in quality improvement and performance credit their systems for continuous measurement and feedback as vital to their success.

We have over our first six years developed a solid reputation for producing high-calibre reports that helped identify gaps in quality of health care *at a given point in time*. The new Quality Insight program we launched in October 2008 builds on that strength by ensuring follow-up measurement and monitoring of quality *over time*.

Fundamentally, the Quality Insight program is about creating – in collaboration with health system leaders and providers – a system of measurement and reporting that will help them bring about improvement. This important endeavor is being steered by the Quality Insight Working Group (QIWG), which currently involves representatives of all health regions, the Saskatchewan Cancer Agency, HQC, and the Ministry of Health.

The group is helping us:

- identify key focus areas for measurement;
- design the reporting products (paper and web) so they are as useful as possible for their intended audiences (health system leaders, clinical leaders);

- establish networks of people with subject-matter expertise, so that the measures we develop and report on are valid and useful to accelerate improvement work; and,
- ensure members have leadership sponsors, to connect their involvement in the Quality Insight program with health region leadership and their strategic work, including Quality as a Business Strategy.

The 2008 edition included updated data on key topics that HQC reported on in previous "quality gap" reports. In a commentary section of this inaugural report, we observed that limited access to timely data and the absence of an electronic health record are restricting the ability of the Health Quality Council, health care providers, and system leaders to make health care better.

Next year's Quality Insight report will again update data on the original family of topics. Where the first report was organized around specific diseases or care locations, the 2009 edition will be organized around a quality measurement framework that is based on dimensions of quality (effectiveness, safety, responsiveness/patient-centredness, equity, efficiency) and the essential functions of health care (helping people stay healthy, get better, live with chronic diseases, die with dignity).

Official release of the 2009 report is slated for early winter. The fact

that we release this information publicly reflects not only our mandate, but also a shared commitment to transparency within Saskatchewan's health care system.

We are currently working with the Canadian Institute for Health Information (CIHI) and other provincial quality councils to develop some measures of hospital patient safety. We're also developing measures of the quality of stroke care across the care continuum (prevention, acute care, rehabilitation, and care in the community) that we hope to include in our 2010 report.

Our aim is for Quality Insight to become a valued resource for health care leaders and decision-makers in their quest for continuous improvement. We will achieve this by staying attuned to the needs of this audience and ensuring Quality Insight complements the performance improvement and quality measurement work being done by the health regions, Saskatchewan Cancer Agency, and the Ministry of Health.

Our longer-range vision is that Quality Insight will become a "one-stop shop," where health system leaders and clinical leaders can find all of the information they need to understand how well health care at a provincial level – and in their own jurisdiction – is progressing toward common, aligned performance goals.

Visit our website for the Quality Insight report



SPREADING AND SUSTAINING
EFFECTIVE PRACTICES

Although the first Collaborative officially wound down in March 2009, it leaves behind a legacy that continues to improve care for patients and sets the stage for the success of another large-scale improvement initiative, this one focused on depression and Chronic Obstructive Pulmonary Disease (COPD).

CHRONIC DISEASE MANAGEMENT COLLABORATIVE (CDMC)

Launched in November 2005, the first Chronic Disease Management Collaborative brought together more than a quarter of all family doctors in the province and hundreds of other health care workers – from all 13 health regions – in the name of improving care for people with diabetes and coronary artery disease. As a result of the initiative, health care professionals are working together in new ways and trying innovative approaches to managing chronic disease.

The Collaborative, the largest improvement project ever undertaken in Saskatchewan, was all about supporting practices to apply and continue using over the long term proven best practices for these disease conditions and for improving access to medical appointments. Some 18,000 patients are receiving better care and access to care, and experiencing better health outcomes, thanks to the project.

Although the first Collaborative officially wound down in March 2009, it leaves behind a legacy that continues to improve care for patients and sets the stage for the success of another large-scale improvement initiative, this one focused on depression and Chronic Obstructive Pulmonary Disease (COPD). Last June we brought together experts and stakeholders for a one-day session to identify current gaps in care for these chronic conditions and discuss how a second Collaborative could help address these gaps. Content for

CDMC II will be based on this dialogue.

Rates of COPD are climbing at an alarming pace in this province. The new Collaborative will focus on guidelines from the Canadian Thoracic Society aimed at reducing emergency room visits, hospitalizations, and urgent visits to family doctors. Similarly, there is room to improve depression care in the province. In North America more than 80% of all cases are diagnosed, managed, and treated in primary care. CDMC II will spread in participating practices the application of recommendations around screening for depression, ongoing use of assessment tools, and more timely involvement of mental health professionals.

Collaborative Facilitators in each health region and the electronic disease registry and decision support tool (CDM Toolkit) continue to be available as supports to practices from the first CDM Collaborative and will serve as important infrastructure for the second. Over the past year, HGC has been supporting the Ministry of Health to make the CDM Toolkit available to all providers in the province; it is slated to be ready province-wide in fall 2009. Working closely with our clinical leads, we have developed new flowsheets for COPD and depression care, which will be integral to the second CDM Collaborative.

The first Learning Workshop for the CDMC II runs in early November 2009.

Visit our website
to see full results on CDMC I

REDUCING WAITS FOR BREAST CANCER CARE

Our 2006 report on breast cancer care in Saskatchewan found that wait times to see physicians, access diagnostic tests, and begin treatment were longer than suggested guidelines. The greatest variation was in the time between detection and biopsy.

Over the past year, improvement teams in Prince Albert Parkland and Saskatoon health regions have continued their work to apply best practices in redesigning the detection-to-diagnosis phase of care to make it more timely and patient-centred. These interdisciplinary groups involve patients and providers involved in breast cancer care, including family doctors, surgeons, radiologists, radiology technologists, and hospital administrators.

Both teams have identified unnecessary steps on the path from suspicion of breast cancer to diagnosis, and potential solutions for reducing wait times and improving patient flow, including same-day consultation between radiologists and surgeons, a clinical algorithm to help family doctors make care decisions, standardized radiology reports, and same-day biopsies where possible. Early results look promising. If changes in processes are sustained, wait times should fall.

See our website for report
on breast cancer care



INFORMING POLICY THAT
SUPPORTS QUALITY IMPROVEMENT

We continued our work to advance support for increased transparency and promote open reporting on health system quality and performance as a means to better care here in Saskatchewan.

Much of the work we've done over the past year has been directly or indirectly related to promoting health care policy grounded in improvement. CEO Bonnie Brossart became a member of Leadership Council, a dynamic forum involving senior leaders from health regions and government. HQC was the only organization in the province invited to provide advice to and participate on the steering committee for the Patient First Review.

We invited the Minister of Health to be part of a team that travelled to the UK to learn more about the innovative Releasing Time to Care[®] program, and see first-hand how policy can support improvement. As part of a province-wide rollout of the Chronic Disease Management Toolkit, we informed the Ministry on how this patient registry enables monitoring improvements in process and outcome measures. HQC was also invited to participate in discussions with the Saskatchewan Medical Association and the Ministry of Health on applying a collective incentive approach to achieving system-level aims around chronic disease management.

ADVANCING TRANSPARENCY

Open, transparent reporting on health system safety and performance is another attribute common to high-performing systems the world over. We continued our work to advance support for increased transparency

and promote open reporting on health system quality and performance as a means to better care here in Saskatchewan. In June, we hosted an exciting workshop entitled "Measuring and Reporting in the Pursuit of Learning and Improvement."

The one-day event featured presenters from health systems across North America that are leading the way in their use of measurement/reporting to deliver safer, more effective care. It attracted nearly 200 leaders from Saskatchewan and across Canada; the interest from outside the province signals that we are leading the country in this area. Our June conference also featured a pair of Saskatchewan doctors who are ahead of the curve in this province. As part of his involvement in the first Chronic Disease Management Collaborative, family physician Werner Oberholzer posted results of his practice's improvement efforts in his waiting area for his patients to see. Saskatoon urologist Kishore Visvanathan blogs about his clinic's efforts to shorten wait times for patients being referred from family doctors.



BOARD OF DIRECTORS



*Marlene Smadu
(Chair)*



*Peter Barrett
(Vice-Chair)*



Ross Baker



Charlyn Black



Maura Davies



Daniel Fox



Eber Hampton



Don Halum



Cecile Hunt



Dennis Kendel



Steven Lewis



Yvonne Shevchuk

HEALTH QUALITY COUNCIL STAFF



FINANCIAL STATEMENTS

21,384

10,857

8,749

8,339

2,239

2,260

6,510

6,079

REPORT OF MANAGEMENT

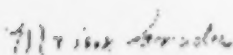
Management is responsible for the integrity of the financial information reported by the Health Quality Council (HQC). Fulfilling this responsibility requires the preparation and presentation of financial statements and other financial information in accordance with Canadian generally accepted accounting principles that are consistently applied, with any exceptions specifically described in the financial statements.

The accounting system used by the HQC includes an appropriate system of internal controls to provide reasonable assurance that:

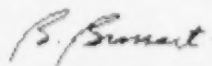
- transactions are authorized;
- the assets of the HQC are protected from loss and unauthorized use; and
- the accounts are properly kept and financial reports are properly monitored to ensure reliable information is provided for preparation of financial statements and other financial information.

To ensure management meets its responsibilities for financial reporting and internal control, board members of the HQC discuss audit and financial reporting matters with representatives of management at regular meetings. HQC board members have also reviewed and approved the financial statements with representatives of management.

The Provincial Auditor of Saskatchewan has audited the HQC's statement of financial position, statement of operations, statement of changes in net financial assets, and statement of cash flows. His responsibility is to express an opinion on the fairness of management's financial statements. The Auditor's report outlines the scope of his audit and his opinion.



Marlene Smadu
Board Chair



Bonnie Brossart
Chief Executive Officer

Saskatoon, Saskatchewan
May 08, 2009

AUDITOR'S REPORT

To the Members of the Legislative Assembly of Saskatchewan

I have audited the statement of financial position of the Health Quality Council as at March 31, 2009 and the statements of operations, change in net assets, and cash flows for the year then ended. The Council's management is responsible for preparing these financial statements for Treasury Board's approval. My responsibility is to express an opinion on these financial statements based on my audit.

I conducted my audit in accordance with Canadian generally accepted auditing standards. Those standards require that I plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In my opinion, these financial statements present fairly, in all material respects, the financial position of the Health Quality Council as at March 31, 2009 and the results of its operations and its cash flow for the year then ended in accordance with Canadian generally accepted accounting principles.

Regina, Saskatchewan
May 8, 2009


Fred Wendel, CMA, CA
Provincial Auditor

STATEMENT OF FINANCIAL POSITION

STATEMENT 1 HEALTH QUALITY COUNCIL

As at March 31	2009	2008
	(thousands of dollars)	
Financial assets		
Cash	\$ 14,480	\$ 6,135
Accounts receivable	68	82
Accrued interest receivable	-	9
Short-term investments	-	2,445
	<u>14,548</u>	<u>8,671</u>
Liabilities		
Accounts payable	166	220
Payroll liabilities	197	154
Other payables (Note 4)	5,017	-
Deferred revenues (Note 5)	6,323	5,915
	<u>11,703</u>	<u>6,289</u>
Net financial assets	<u>2,845</u>	<u>2,382</u>
Non-financial assets		
Tangible capital assets (Note 2c & Note 3)	96	88
Prepaid expenses and deposits	39	45
	<u>135</u>	<u>133</u>
Accumulated surplus	\$ <u>2,980</u>	\$ <u>2,515</u>
Contractual commitments (Note 11)		

(See accompanying notes to the financial statements)

STATEMENT OF OPERATIONS

STATEMENT 2 HEALTH QUALITY COUNCIL

For the year ended March 31

	2009		2008
	Budget (Note 9)	(thousands of dollars) Actual	Actual
Revenue			
Saskatchewan Health			
- General Revenue Fund	\$ 5,150	\$ 5,150	\$ 5,150
- Technical Efficiency (Note 5a)	61	83	227
Other (Note 6)	148	152	99
Interest	-	91	103
Conferences	120	81	79
Safer Healthcare Now!	-	54	50
	<u>5,479</u>	<u>5,611</u>	<u>5,708</u>
Expenses			
Project funding	1,385	875	968
Grants	86	225	221
Wages and benefits	3,494	3,216	2,988
Travel	284	276	145
Administrative and operating expenses	188	128	232
Honoraria and expenses of the board	149	105	116
Amortization expense	50	52	43
Rent	250	269	201
	<u>5,886</u>	<u>5,146</u>	<u>4,914</u>
Annual surplus	\$ (407)	465	794
Accumulated surplus, beginning of year		2,515	1,721
Accumulated surplus, end of year		<u>\$ 2,980</u>	<u>\$ 2,515</u>

(See accompanying notes to the financial statements)

STATEMENT OF CHANGE IN NET ASSETS

STATEMENT 3 HEALTH QUALITY COUNCIL

For the year ended March 31

	<u>2009</u>	<u>2008</u>
	(thousands of dollars)	
Annual surplus	<u>\$ 465</u>	<u>\$ 794</u>
Acquisition of tangible capital assets	(60)	(38)
Amortization of tangible capital assets	<u>52</u>	<u>43</u>
	<u>(8)</u>	<u>5</u>
Acquisition of prepaid expenses	(39)	(45)
Use of prepaid expenses	<u>45</u>	<u>25</u>
	6	(20)
Increase in net financial assets	463	779
Net financial assets, beginning of year	<u>2,382</u>	<u>1,603</u>
Net financial assets, end of year	<u><u>\$ 2,845</u></u>	<u><u>\$ 2,382</u></u>

(See accompanying notes to the financial statements)

STATEMENT OF CASH FLOWS

STATEMENT 4 HEALTH QUALITY COUNCIL

For the year ended March 31

	2009	2008
	(thousands of dollars)	
Operating activities		
Cash received from		
Saskatchewan Health - General Revenue Fund	\$ 10,550	\$ 10,650
Saskatchewan Medical Association	-	200
Interest income	222	130
Safer Healthcare Now!	-	104
Conference	107	83
Other	165	42
	<u>11,044</u>	<u>11,209</u>
Cash paid for		
Wages and benefits	3,173	2,964
Supplies and other	495	952
Project funding	1,172	1,209
Grants	244	162
	<u>5,084</u>	<u>5,287</u>
Cash provided by operating activities	<u>5,960</u>	<u>5,922</u>
Capital activities		
Purchases of tangible capital assets	(60)	(57)
Cash used in capital activities	<u>(60)</u>	<u>(57)</u>
Investing activities		
Purchase of investments	(7,737)	(6,914)
Disposal of investments	10,182	6,466
Cash provided by investing activities	<u>2,445</u>	<u>(448)</u>
Increase in cash	8,345	5,417
Cash, beginning of year	<u>6,135</u>	<u>718</u>
Cash, end of year	<u>\$ 14,480</u>	<u>\$ 6,135</u>

(See accompanying notes to the financial statements)

NOTES TO THE FINANCIAL STATEMENTS

HEALTH QUALITY COUNCIL March 31, 2009

1. Establishment of the Council

The **Health Quality Council Act** was given royal assent July 10, 2002 and proclaimed on November 22, 2002. The Health Quality Council (HQC) measures and reports on quality of care in Saskatchewan, promotes continuous quality improvement, and engages its partners in building a better health system. HQC commenced operations on January 1, 2003.

2. Accounting Policies

Pursuant to standards established by the Public Sector Accounting Board (PSAB), HQC is classified as an other government organization. HQC uses Canadian generally accepted accounting principles applicable to governments. The following accounting policies are considered to be significant:

a) Operations

For the operations of HQC, the primary revenue is contributions from the Saskatchewan Ministry of Health (Ministry of Health) – General Revenue Fund. Other sources of revenue include conference registrations, interest and miscellaneous revenue. Unrestricted contributions are recognized as revenue in the year received or receivable if the amount can be reasonably estimated and collection is reasonably assured. Restricted contributions are deferred and recognized as revenue in the year which related expenses are incurred. Interest earned on restricted contributions accrues to the benefit of the restricted program.

b) Measurement Uncertainty

The preparation of financial statements in accordance with PSAB accounting principles requires HQC's management to make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosure of commitments at the date of the financial statements and the reported amounts of revenue and expenses during the period. Actual results could differ from those estimates.

c) Tangible Capital Assets

Tangible capital assets are reported at cost less accumulated amortization. Purchases valued at \$250 or greater are recorded as a capital asset. Leasehold improvements are amortized over the length of the lease; the current lease expires in July 2012. Amortization is recorded on a straight-line basis at rates based on estimated useful lives of the tangible capital assets as follows:

Office Furniture	10 years
Office Equipment	5 years
Computer Hardware	3 years
Computer Software	3 years
Leasehold Improvements	4 years

Normal maintenance and repairs are expensed as incurred.

NOTES TO THE FINANCIAL STATEMENTS

3. Tangible Capital Assets

The recognition and measurement of tangible capital assets is based on their service potential. These assets will not provide resources to discharge liabilities of HQC.

	Office Furniture & Equipment	Computer Hardware & Software	Leasehold Improvements	2009 Totals	2008 Totals
	(thousands of dollars)				
Opening cost	\$ 150	\$ 286	\$ 60	\$ 496	\$ 467
Additions	1	58	1	60	38
Disposals	(1)	(29)	-	(30)	(9)
Closing cost	<u>150</u>	<u>315</u>	<u>61</u>	<u>526</u>	<u>496</u>
Opening accumulated amortization	97	259	52	408	374
Amortization	12	38	2	52	43
Disposals	(1)	(29)	-	(30)	(9)
Closing accumulated amortization	<u>108</u>	<u>268</u>	<u>54</u>	<u>430</u>	<u>408</u>
Net book value of tangible capital assets	<u>\$ 42</u>	<u>\$ 47</u>	<u>\$ 7</u>	<u>\$ 96</u>	<u>\$ 88</u>

4. Other Payables

(a) Releasing Time to Care®

Releasing Time to Care® is a program developed by the NHS Institute for Innovation and Improvement that HQC is currently testing with Regina Qu'Appelle and Five Hills Regional Health Authorities. It is a patient-centred approach to improving the quality of care on acute care nursing units, by freeing up caregivers' time for more direct patient care.

HQC has entered into agreements with Regina Qu'Appelle and Five Hills regional health authorities that require HQC to provide funding in support of the implementation of Releasing Time to Care®.

(b) Other

In March 2009, HQC received \$5 million from the Ministry of Health for payments to the regional health authorities as directed by the Ministry of Health.

NOTES TO THE FINANCIAL STATEMENTS

5. Deferred Revenue

	Beginning balance	Amount received	Amount recognized	Ending balance
	(thousands of dollars)			
Technical Efficiency	\$ 661	\$ 10	\$ 183	\$ 488
Accelerating Excellence	5,000	212	-	5,212
Saskatchewan Medical Association	200	-	2	198
Safer Healthcare Now!	54	-	54	-
Patient Exit Survey	-	250	-	250
The First Nations and Métis Indicator Initiative	-	150	-	150
Other	-	25	-	25
Totals	<u>\$ 5,915</u>	<u>\$ 647</u>	<u>\$ 239</u>	<u>\$ 6,323</u>

(a) Technical Efficiency

The Minister of Health established a \$1 million Technical Efficiency Program (TE) in February 2005. The Ministry has entrusted HQC to manage and coordinate the TE, which is designed to assess and evaluate those areas of the health care system that could benefit from the application of one or more process improvements:

- (a) health system productivity,
- (b) timeliness of health care delivery and services,
- (c) health outcomes, and
- (d) overall patient, public and provider satisfaction with the health system.

A signed agreement describes the responsibilities of the Ministry of Health and HQC. The Ministry of Health approves all projects and payments that are to be funded through the TE. The original term of this agreement was March 1, 2005 to March 31, 2007. The agreement has been extended to March 31, 2010.

HQC reduced the deferred revenue by \$182,926 (2008 - \$227,002) including \$100,000 that was transferred to Accelerating Excellence. Interest earned of \$9,655 on the balance of the deferred revenue for this program was allocated to the program.

Unless otherwise directed by the Ministry, HQC will return all unexpended funds to the Ministry upon expiration of the agreement.

(b) Accelerating Excellence

The Ministry of Health established a \$5 million Accelerating Excellence Program (AE) in March 2008. The Ministry has entrusted HQC to manage and coordinate the AE. A signed agreement describes the responsibilities of the Ministry and HQC. The Ministry approves all projects and payments that are to be funded through the AE. The term of this agreement is March 31, 2009 to March 31, 2012.

NOTES TO THE FINANCIAL STATEMENTS

AE is an investment in redesigning health care delivery in a handful of Saskatchewan organizations, by applying approaches and lessons learned elsewhere in the world. The money will be used to:

- (a) build capacity for improvement (with leadership, middle management, front-line providers and staff, and physicians),
- (b) provide protected time for people to learn and apply their knowledge and tools, and,
- (c) build the infrastructure needed to measure the impact of these changes.

AE received a transfer of \$100,000 from Technical Efficiency (see Note 5a). Interest earned of \$112,094 on the balance of the deferred revenue for this program was allocated to the program.

Unless otherwise directed by the Ministry, HQC will return all unexpended funds to the Ministry upon expiration of the agreement.

(c) Saskatchewan Medical Association

The Saskatchewan Medical Association (SMA) has provided HQC with a contribution towards the next Chronic Disease Management Collaborative (CDMC). SMA has designated the contribution to partially offset the time and expenses incurred by physicians that participate in the next CDMC.

(d) Patient Exit Survey

The Ministry of Health has provided HQC with \$250,000 in support of the Patient Exit Survey. This survey evaluates patients' point of care experiences in Saskatchewan acute care hospitals. The survey has been created to allow for comparability across hospitals with quarterly reporting, or monthly for a few hospitals.

(e) The First Nations and Métis Indicator Initiative

The Ministry of Health and HQC have made an agreement for HQC to undertake the comprehensive project titled "The First Nations and Métis Indicator Initiative". The project began on March 23, 2009 and ends on March 31, 2010. The objectives of the project are:

- (a) provide an information tool for First Nations and Métis health system leaders to help guide decisions on health care services and the population they serve, and
- (b) develop a First Nations and Métis health indicator framework or frameworks that will look at each population separately.

Unless otherwise directed by the Ministry, HQC will return all unexpended funds to the Ministry upon expiration of the agreement.

(f) Other

HQC will facilitate the Quality Improvement Consultant School (QIC) in the fall of 2009. Pre-registrations for QIC have been accepted and the monies deferred until fiscal 2009 - 2010.

NOTES TO THE FINANCIAL STATEMENTS

6. Other Income

Other income recorded by HQC is comprised of cost recoveries and honorariums.

As well, HQC received awards from the Canadian Health Services Research Foundation for projects undertaken. The monetary awards received were \$10,500 (2008 - \$36,300).

Cost recoveries of \$35,159 (2008 - \$54,491) from the University of Saskatchewan are included in other income.

7. Related Party Transactions

Included in these financial statements are transactions with various Saskatchewan Crown Corporations, ministries, agencies, boards, and commissions related to HQC by virtue of common control by the Government of Saskatchewan, and non-crown corporations and enterprises subject to joint control or significant influence by the Government of Saskatchewan (collectively referred to as "related parties"). Other transactions with related parties and amounts due to or from them are described separately in these financial statements and notes thereto.

Routine operating transactions with related parties are recorded at the standard rates charged by those organizations and are settled on normal trade terms.

HQC pays Provincial Sales Tax to the Saskatchewan Ministry of Finance on all its taxable purchases. Taxes paid are recorded as part of the cost of those purchases.

	2009	2008
	(thousands of dollars)	
Revenue		
Regional Health Authorities	\$ 29	\$ -
University of Saskatchewan	35	54
Expenses		
Capital Pension Plan	164	139
Saskatchewan Opportunities Corporation - Innovation Place	303	235
Regional Health Authorities	168	789
Saskatchewan Association of Health Organizations	-	7
SaskTel	11	10
Saskatchewan Ministry of Finance	1	16
Saskatchewan Health Information Network	7	51
University of Saskatchewan	7	35
Accounts Payable		
Saskatchewan Opportunities Corporation - Innovation Place	32	13
Regional Health Authorities	24	102
Saskatchewan Ministry of Finance	-	16
Saskatchewan Health Information Network	7	-
Accounts Receivable		
Ministry of Health	45	-
Regional Health Authorities	5	-
University of Saskatchewan	-	54

NOTES TO THE FINANCIAL STATEMENTS

8. Financial Instruments

HQC has the following financial instruments: accounts receivable, accounts payable, and accrued payroll liabilities. The following paragraphs disclose the significant aspects of these financial instruments. HQC has policies and procedures in place to mitigate the associated risk.

a) Significant terms and conditions

There are no significant terms and conditions associated with the financial instruments that may affect the amount, timing, and certainty of future cash flows.

b) Interest rate risk

HQC is exposed to interest rate risk when the value of its financial instruments fluctuates due to changes in market interest rates. HQC does not have any long-term investments that may be affected by market pressures.

HQC's receivables and payables are non-interest bearing.

c) Credit risk

HQC is exposed to credit risk from potential non-payment of accounts receivable.

Most of HQC's receivables are from provincial agencies and the federal government; therefore, the credit risk is minimal.

d) Fair Value

For the following financial instruments, the carrying amounts approximate fair value due to their immediate or short-term nature:

Accounts receivable
Accounts payable
Accrued payroll liabilities

9. Budget

These amounts represent the operating budget approved by the Board of Directors.

10. Pension Plan

HQC is a participating employer in the Capital Pension Plan, a defined contribution pension plan. Eligible employees make monthly contributions of 6.35% of gross salary, which are matched by HQC. HQC's contributions for this fiscal year were \$164,123 (2008 - \$138,602).

NOTES TO THE FINANCIAL STATEMENTS

11. Contractual Commitments

As of March 31, 2009, HQC had the following commitments:

a) Office Rent

HQC has a lease for office space with Innovation Place. The lease has been extended to July 31, 2012. The monthly cost is \$20,439, for the period of August 1, 2007 to July 31, 2012.

b) National Research Corporation Canada

HQC has contracted the National Research Corporation Canada to conduct a survey regarding patient satisfaction throughout all Saskatchewan regional health authorities. The National Research Corporation Canada will be responsible for collecting, processing and reporting survey results to HQC.

Under the agreed work schedule the deliverables will be provided by June 30, 2009, with a cost of \$159,515.

AUDITOR'S REPORT

To: The Members of the Legislative Assembly of Saskatchewan

I have audited Health Quality Council's control as of March 31, 2009 to express an opinion as to the effectiveness of its control related to the following objectives.

- To safeguard public resources. That is, to ensure its assets are not lost or used inappropriately; to ensure it does not inappropriately incur obligations; to establish a financial plan for the purposes of achieving its financial goals; and to monitor and react to its progress towards the objectives established in its financial plan.
- To prepare reliable financial statements.
- To conduct its activities following laws, regulations and policies related to financial reporting, safeguarding public resources, revenue raising, spending, borrowing, and investing.

I used the control framework developed by The Canadian Institute of Chartered Accountants (CICA) to make my judgements about the effectiveness of Health Quality Council's control. I did not audit certain aspects of control concerning the effectiveness, economy, and efficiency of certain management decision-making processes.

The CICA defines control as comprising those elements of an organization that, taken together, support people in the achievement of the organization's objectives. Control is effective to the extent that it provides reasonable assurance that the organization will achieve its objectives.

Health Quality Council's management is responsible for effective control related to the objectives described above. My responsibility is to express an opinion on the effectiveness of control based on my audit.

I conducted my audit in accordance with standards for assurance engagements established by The Canadian Institute of Chartered Accountants. Those standards require that I plan and perform an audit to obtain reasonable assurance as to effectiveness of Health Quality Council's control related to the objectives stated above. An audit includes obtaining an understanding of the significant risks related to these objectives, the key control elements and control activities to manage these risks and examining, on a test basis, evidence relating to control.

Control can provide only reasonable and not absolute assurance of achieving objectives reliably for the following reasons. There are inherent limitations in control including judgement in decision-making, human error, collusion to circumvent control activities and management overriding control. Cost/benefit decisions are made when designing control in organizations. Because control can be expected to provide only reasonable assurance and not absolute assurance, the objectives referred to above may not be achieved reliably. Also, projections of any evaluation of control to future periods are subject to the risk that control may become ineffective because of changes in internal and external conditions, or that the degree of compliance with control activities may deteriorate.

In my opinion, based on the limitations noted above, Health Quality Council's control was effective, in all material respects, to meet the objectives stated above as of March 31, 2009 based on the CICA criteria of control framework.

Regina, Saskatchewan
May 8, 2009



Fred Wendel, CMA, CA
Provincial Auditor

AUDITOR'S REPORT

To: The Members of the Legislative Assembly of Saskatchewan

I have made an examination to determine whether the Health Quality Council, complied with the provisions of the following legislative and related authorities pertaining to its financial reporting, safeguarding public resources, spending, revenue raising, borrowing and investing activities during the year ended March 31, 2009:

The Health Quality Council Act

The Tabling of Documents Act, 1991

Orders in Council issued pursuant to the above Acts

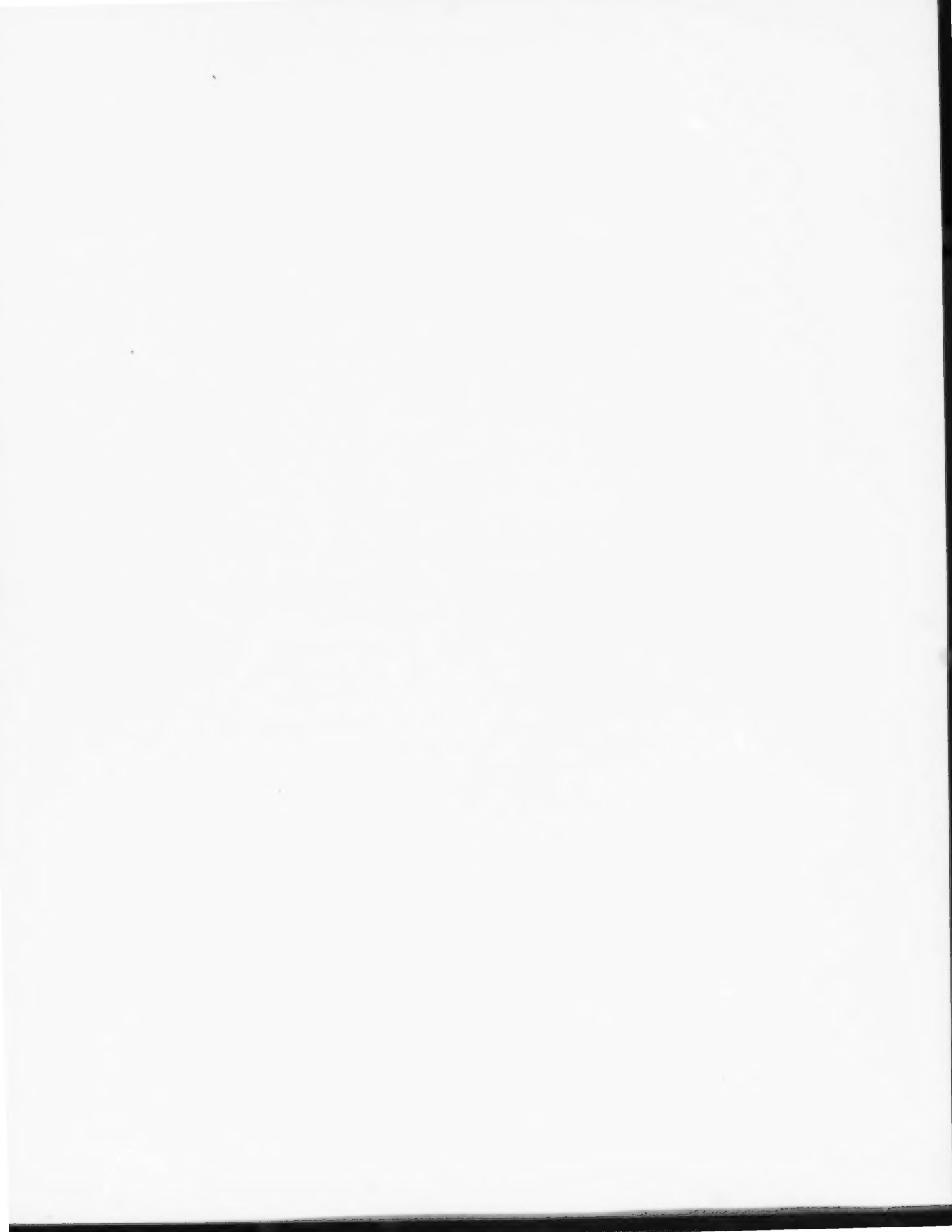
My examination was made in accordance with Canadian generally accepted auditing standards, and accordingly included such tests and other procedures as I considered necessary in the circumstances.

In my opinion, the Health Quality Council has complied, in all significant respects, with the provisions of the aforementioned legislative and related authorities during the year ended March 31, 2009.



Fred Wendel, CMA, CA
Provincial Auditor

Regina, Saskatchewan
May 8, 2009



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QUALITY
COUNCIL



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